

	Sutter Health Plus \$20 Copay HMO	Sutter Health Plus \$1500 Deductible	**Kaiser \$25 Copay	**Kaiser \$1500 Deductible	**Blue Shield \$100 Deductible PPO	
	In Network	In Network	In Network	In Network	In Network	Out of Network
Annual Deductible						
For one person	None	\$1,500	None	\$1,500	\$100 ^(a)	\$100 ^(a)
For your family	None	\$3,000	None	\$3,000	\$200 ^(a)	\$200 ^(a)
Out-of-Pocket Maximum						
For one person	\$1,500	\$4,000	\$1,500	\$4,000	\$2,100 ^(a)	\$2,100 ^(a)
For your family	\$3,000	\$8,000	\$3,000	\$8,000	\$4,200 ^(a)	\$4,200 ^(a)
Doctor's Office Visits						
Primary Care (PCP)	\$20 copay	\$20 copay	\$25 copay	\$40 copay	\$25 copay	30%*
Specialists	\$20 copay	\$20 copay	\$25 copay	\$40 copay	\$25 copay	30%*
X-rays, lab work, etc.						
During an office visit	No charge if at an in-network facility	\$10 per visit MRI, CT, PET-\$50 per visit	No Charge	\$10 copay*	\$25 copay	30%*
At an outside facility	Not Covered	Not Covered	No Charge	\$10 copay*	10%*	30%*
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge	Not Covered
Hospital Care						
Inpatient	\$100 per admission copay	30%*	\$100 admission copay	30%*	10%*; additional \$100 admission copay	30%*(b)
Outpatient	\$100 per visit	30%*	\$100 surgery copay	30%*	10%*; additional \$100 surgery copay	30%*(c)
Emergency Care						
Emergency Room	\$100 copay	30%*	\$100 copay	30%*	\$100 copay	\$100 copay
Ambulance	\$50 per trip	No charge*	No Charge	\$150 copay*	10%*	10%*
Prescription Drugs						
Retail	(30 day supply) \$10/\$30/\$60/20% maximum \$100 per prescription	(30 day supply) \$10/\$30/\$60/30% maximum \$100 per prescription	(30 day supply) \$10 generic \$25 brand	(30 day supply) \$10 generic \$30 brand	(30 day supply) \$10 generic \$25 brand \$40 non-formulary	25%+\$10 generic 25%+\$25 brand ^(d) 25%+\$40 non-formulary
Mail Order	(100 day Supply) ^(e) \$20/\$60/\$120/20%* ^(e) maximum \$100 per prescription	(100 day supply) \$20/\$60/\$120* ^(e) maximum \$100 per prescription	(100 day supply) \$20 generic \$50 brand	(100 day supply) \$20 generic \$60 brand	(90 day supply) \$20 generic \$50 brand \$80 non-formulary	Not Covered
Mental Health Services						
Inpatient Hospital	\$100 per admission copay	30%*	\$100 per admission copay	30%*	10%*; additional \$100 admission copay	30%*(b)
Outpatient Office Visit- indiv.	\$20 per visit	\$20 per visit	\$25 per visit	\$40 per visit	\$25 per visit	30%*(b)
Outpatient Office Visit- Group	\$10 per visit	\$10 per visit	\$12 per visit	\$20 per visit	N/A	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

**Pending Finalized SBCs.

*After deductible is paid.

(a)Combined for all providers.

(b)Maximum allowable per day benefit of \$600. Members are responsible for amounts over the allowable amount.

(c) Maximum allowable per day benefit of \$350. Members are responsible for amounts over the allowable amount.

(d)Separate \$250 deductible applies for brand prescriptions.

(e)Not all Tier 4 prescriptions are eligible for mail order. Tier 4 mail order prescriptions have a 30 day supply limit.

The information in this Comparison presents an overview of certain medical benefit plan services and is intended for informational purposes only.

If there is a difference between the overview and the official Plan Document, the Plan Document (which may include underlying contracts) will govern.

Please consult the Plan Document for additional information which is located on the City's Human Resources website: <http://www.sjcity.net/index.aspx?NID=238>.

Benefit Plans contained in this Comparison may not be available to all employees; employees are eligible for benefits according to their classification and their Bargaining Unit Memorandum of Agreement.